TOWARD A GOVERNMENT POLICY ON DRUG ABUSE

A Position Paper Presented to

The Legislature of the Province of British Columbia

at Victoria, British Columbia

Friday, March 2nd, 1973

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THE HONOURABLE NORMAN LEVI

Minister of Rehabilitation and Social Improvement

Province of British Columbia

INTRODUCTION

British Columbia has the unique position of having more drug addicts, alcoholics and soft drug users (not confirmed) per capita than any other province in Canada. In fact, we have over 50 per cent of the known heroin users. The failure of the previous government to adopt a policy on drug dependency has led to the near panic reactions that are evident in the Province. It is safe to say that no community in the Province is drug free. In the past two weeks I have attended three public meetings at which over a thousand people, mostly parents, attended. There is no question that every M.L.A. could call such meetings and the turnout would be very high.

People who are parents are seeking answers to their children's drug problems, spouses with drinking problems, and an explanation of what is happening to our society.

We are an open government. We are having contact with people in a way that no other government has ever done. The drug dependency problem is a community problem and it is our duty to make available to those communities the kind of help they need. We must consult with them and help them provide the services. In the past, centralized decision-making has led to great frustration by the communities and has encouraged professional groups to dominate the field of services to people. We must give this function back to the communities.

A PHILOSOPHY TO THE APPROACH OF DRUG ABUSE WITHIN THE COMMUNITY RESOURCES PROGRAMME

There is no known cure, as such, for the problem of drug abuse. The solutions lie only within the individual drug abuser and within the people of his community.

There are no professional experts who we can bring in to solve the drug abuse problem.

However, we are fortunate to have hundreds and thousands of preventative experts in every community. They are the people who do the work of our Province. They are the people who raise healthy families, are good neighbours and good friends. They are the men and women who give their love and concern and their time to their children and to the people of the community. They are the people who have the greatest gift of all. They have the gift of giving. In return for this they receive the greatest gift of all. They receive the love and respect of others and their own self-respect. They receive a sense of fulfillment. They receive their euphoria through living and giving. They need no chemicals to obtain their "highs". Their "highs" come from effective living. They have the only solution there is to the problem of drug abuse. They have no need for the constant and excessive use of mood altering chemicals. By giving of themselves they have found something far better than any chemical. This is their immunity -- and it is the only real prevention there is.

If we wish to find a solution to drug abuse, we had better look to these people. Our problems and our solutions lie within ourselves. A community's problems and solutions lie within itself.

There is only one control for drug abuse and that is self-control. It means finding something better out of life than can be found in a glass or in a capsule. It means effective living. Only the parent who gives of self to spouse and children can pass on that self-control to his children. In the long run, the prevention of drug abuse will be done in the family or will not be done at all.

In any community all adults can be parents to all children. It is in the individual family and in the larger family,

known as the community, that prevention and solution to drug abuse will be found through effective living, or it will not be found.

Over the years, at different times and in different places on this continent there have been professional programmes and institutions attempting to meet the problem of drug abuse. They have all failed while the problem has increased.

When it comes to drug abuse there are no experts. The closest to it is the person who has gone the route to alcoholism or addiction and eventually has faced up to the simple fact that his problems lie within himself, but he is the first to tell you that he is only an expert for himself. The person who has overcome drug abuse problems has most often followed the path of self-help by helping others. By giving to others, his own inner needs have been met. This is basic to Alcoholics Anonymous philosophy, and it is basic to life. It is the gift of giving. It is the greatest resource in any human being and in any community, and to work out solutions to drug abuse, we are going to have to call upon it.

No one can go into a community and offer a solution to drug abuse or to most of the other related human problems, but we do know that the solutions lie where the problems are; within individuals, within families and within communities.

The people in the big "family" of B.C. have been and are, calling out for help with the very real problems of drug abuse.

In our hearts we know that the only help is self-help, and self-help is helping others.

It is the duty of the government to provide each community with the basis to examine, define and solve our human problems on a face-to-face basis.

This is the long-range goal of the government. There will be no exotic programmes (or imported pedigree professionals), but there will be people made available in each community to start what we have called "THE COMMUNITY RESOURCES PROGRAMME".

What kind of a programme this is will be determined by what we are as human beings, but nothing else.

DRUG ABUSE COMMISSION - A PROPOSAL

As a government we must meet these demands of various communities. This requires that we have an integrated approach to the total problem of drug dependency. Frankly, this can only be achieved if we set up a drug dependency commission. The commission would be responsible for administering all money now being spent through five departments of government and integrate money spent by two federal departments. All drug dependency decision making should be co-ordinated through the commission. Attached are recommendations on the function of such a commission.

The Government of British Columbia convened a Drug Dependency Conference on January 9th and 10th, 1973, in Victoria. (See Appendix A). A number of recommendations were proposed by the conference. (See Appendix B). These recommendations are the basis of the attached report as well as other input from specialists in the field who have been consulted after the conference.

AN ACT TO SET UP A COMMUNITY RESOURCES COMMISSION FOR DRUG ABUSE

For the Purposes of this Act, the Following Definitions Shall Apply:

Drug - Any substance that by its chemical nature alters structure or function in the living organism (i.e. sensation, mood, consciousness, psychological or behavioural functions;

Drug Dependency - A state of psychological or physical dependence on a drug following periodic or continued use. Specific characteristics of dependence vary with different drugs and different patterns of use.

Functions (Programmes) of the Commission

1. The Commission may provide community resource workers to:

   (a) assist citizen organizations, groups or individuals to identify those community health resources which are required as a result of drug dependency problems in their communities;

   (b) support those citizen organizations, groups or individuals in the initial development of integrated community health programmes for drug dependent persons (health services, living skills, education, individualized volunteer support for drug dependents, recreation, etc.) and then withdraw.

2. The Commission may provide financial or other assistance to those citizen groups, organizations or individuals conducting community health programmes directed towards minimizing the extent of drug dependency in their community,

or towards conducting programmes for the treatment and rehabilitation of drug dependent persons. (Direct hospital care and/or medical components of a detoxification centre for drug dependent persons would be the responsibility of the Minister of Health Services and Hospital Insurance). (See Appendix C).

3. The Commission may conduct or engage other persons to monitor and evaluate those community health programmes receiving financial support from the Community Resources Commission.

FUNDING PROCEDURE FOR DRUG SPECIFIC AGENCIES:
(i.e. NATIONAL ALCOHOLISM FOUNDATION, BRITISH COLUMBIA ALCOHOLISM FOUNDATION, etc.)

It is the Government's intention to allow such agencies a maximum of two years to modify their present programmes so that they are provided through Community Resource Centres. Our philosophy is that citizen groups, and/or organizations will determine whether to purchase existing services from drug specific agencies. We recognize that certain responsibility for operating programmes (i.e. opiate maintenance), which have been developed by drug specific agencies will not immediately be assumed by Community Resources Centres. Assisting the orderly transfer of responsibility for such programmes will be one of the first tasks of the community resource worker.

In setting up the Commission, let us not mislead the people. We have a responsibility to state very clearly beforehand what we are trying to achieve. We must establish realistic goals--short range achievable goals within an overall plan. We must make sure that we are prepared to correct our mistakes as we go along, and we must be sure that the public knows where we are going every step of the way. If we

are sending out messages, let us be absolutely sure that they are being understood by everyone. The government recently spent $400,000 on drug education. I would suggest, that from talking to young people at whom this programme was aimed, it was an absolute waste of money. Four Hundred Thousand Dollars could have provided over 40 street workers, social workers, community workers, facilities for volunteer groups to reach the people across this province.

There are specific functions for professionals to use their expertise, but at the same time there is an equally important role for the trained volunteer and the recovered alcoholic, the addict who is being maintained on medication or the rare drug-free addict. All are part of the community resource. We have scarce resources--let's use them properly.

RECOMMENDATIONS

In view of the very serious problem of drug dependency in the Province, it is recommended that the Cabinet adopt the following policies:

1) Approve the statement of philosophy.
2) Enact legislation to create a Commission in this Session. (See Appendix D - Alberta legislation). Proposed changes.
3) Appoint a Minister to report to the Legislature on the work of the Commission.
4) Appropriate a sum of money equal to the amount of money now being spent annually from all sources to the Commission for its operation and the funding of Community Resources Centres. (See Appendix E).
5) Call a conference of educators, students, public relation specialists, parents and those people who are addicted, to propose educational programmes as part of preventative measures. (See Appendix F).

6) To discuss with the Federal Government what financial contribution they are prepared to make over and above the $700,000 proposed for 1973/74. (See Appendix G).

7) As a Government, we should be concerned with drug dependency problems with our Civil Service. (See Appendix H).

APPENDIX "A"

C O P Y

Victoria,
British Columbia.

January 2nd, 1973.

Mr. J. C. Karpoff,
Executive Director,
Vancouver Detoxification Society,
Suite 107, 525 Seymour Street,
VANCOUVER 10, British Columbia.

Dear Mr. Karpoff:

The Honourable Dennis Cocke, The Honourable Ernest Hall, The Honourable Eileen Dailly and myself have been discussing future policy with respect to drug dependency in British Columbia, and we are seeking your assistance in developing policy proposals to deal with this problem. We have in mind the presentation of a specific programme of action to the Federal Government which will tell them exactly what we intend. We will, of course, seek their co-operation in terms of financial aid.

I would like to extend to you an invitation to participate in a meeting to be held here in the Parliament Buildings on January 9th and 10th to discuss policy proposals, and I would be pleased if you would confirm your willingness to assist us in this way.

If you would forward to us a brief statement of your views on the subject in order that we can develop an agenda for the policy discussions, it would be appreciated.

Yours sincerely,

NORMAN LEVI,
Minister.

APPENDIX "B"

DRUG DEPENDENCY CONFERENCE - 9th and 10th January 1973

1. Government must take a strong position expressing the undesirability of the excessive use of mood-changing drugs with the objectives of this position being the prevention and treatment of dependency on such drugs and the alleviation of the social and health problems which result from such dependency.

2. The conference suggests that objectives with which Government can deal are:

   (a) the rehabilitation of those patients who are dependent on drugs with the aim of returning the patient to his normal function in the community within the limits of his potential so that he may work productively and refrain from criminal and/or anti-social activity, and

   (b) to provide supervision or custodial care for those persons who are drug dependent and for those persons whose potential for rehabilitation is considered limited that such care is indicated.

3. A positive Public Information programme should be planned and implemented with the aim of promoting constructive life styles. The conference does not agree with negative programming emphasizing drugs which in its opinion may encourage rather than discourage the use of drugs. Such a programme should be continuing and subject to constant evaluation and revision. Some examples are 30-second television ads promoting such positive activities as skiing, chess, political participation, drama, outdoor activities, volunteer social agencies, high cultural activities such as painting, etc. These ads should attach glamour to responsibility and co-operative social participation, rather than failure or anti-social activity.

4. The conference recommends to the Provincial Government that the prevention and treatment of drug dependency be recognized mainly as a "health/social" problem, not as a legal one. The illegal importation, manufacture and sale of drugs should continue to be subject to criminal legal sanctions.

5. The conference recommends to the Provincial Government that there is pressing need for the modification of existing Federal and Provincial legislation as it relates to drug users so that sentencing policies can be worked into the treatment programmes. A compulsory component must be made available for use in the total treatment programme as part of health legislation for those in an intoxicated state for a period of up to one month in order to deal with the acute stage of drug dependency enabling them to develop an awareness of the personal consequences of their behaviour and further acquaint them with the social and health facilities available for the modification of their drug dependent behaviour. We stress that this compulsory component is only valid if

if there is a wide range of follow-up after care programmes in fact available throughout the Province. We believe it is the Provincial Government's responsibility to assure that such a wide range of support treatment programmes be made available and to ensure that new programmes are encouraged.

6. The conference recommends the use and improvement of present organizations. The reorganization of existing structures should continue to make possible the employment of existing personnel.

7. In considering organization of Government structure the conference recommends that the following factors be taken into account:

   (a) Local input

   (b) Flexibility of programming

   (c) The need for inter-disciplinary representation at local and Provincial levels.

   (d) The need for continuing evaluation of programmes

   (e) The need for an inter-departmental Provincial organization for policy making, fund allocation, standard setting, and programme planning.

Drup Dependency Conference - Afternoon Session - 10th January 1973

Detoxification Centres

The Conference recommends to the Provincial Government that it take steps to immediately establish detoxification centres to care for drug dependent persons which would be available in all major dentres and available to all such persons from all areas of the Province.

These detoxification centres would be staffed by "social/health" teams.

The detoxification centre should emphasize the non-medical approach during the detoxification process and, therefore, "social/health" teams would include social workers, non-professional workers, volunteers, and medical personnel.

It is important that where possible, such centres be headed by a non-medical person.

Alcohol Addiction

It is recommended that there be an integration of services working co-operatively.

It is recommended that the Government be encouraged to institute a program of lectures and films for those convicted of driving offences related to the use of alcohol, modeled after the Alberta programme which, in turn, is modeled after the Phoenix programme.

It was also suggested that such convicted drivers might be pressed into service at detoxification centres.

It was recommended that efforts be made to provide drug and alcohol education for native Indians.

Heroin Addiction

It was recommended by the Conference that the Government make efforts to lessen or eliminate policing of treatment agencies from the point of view of enforcing criminal law.

It was also recommended that urinalysis be de-emphasized and used only for the purpose of diagnosing acute situations.

It was recommended that there be no requirement to provide the names and addresses of patients to any government authority so that confidentiality may be protected.

General

It was suggested that further conferences be sponsored by the Provincial Government.

DETOXIFICATION FACILITIES

Detoxification is the process of sobering up, including the period of withdrawal from alcohol. This is a stage in which only medical treatment is necessary and the type of treatment depends on the initial condition of the alcoholic. Possibly 10% of those treated are in bad enough shape to require acute care.

Historically, jails have been used as sobering-up facilities for drunks, and in Vancouver there are still about 1,000 men a month going through the drunk tank. Some of these are released after a night in custody, while others who are considered by a doctor to require remedial care are sent to the Alouette River Unit. Individuals picked up by the Vancouver policy and needing hospital treatment are sent to the Vancouver General Hospital, where they are normally held no more than 24 hours.

In the Lower Mainland area, Hollywood Hospital has for some years provided detoxification facilities under a special arrangement with the B. C. Hospital Insurance Service. The Central City Mission in Vancouver and the Salvation Army's Harbour Light Centre in Victoria both make provision for handling a few men requiring detoxification. In other parts of the Province, detoxification services have been provided by jails and hospitals, and in some cases by halfway houses, but the services have been far from adequate.

Early in 1972 the Detoxification Centre was opened in Vancouver under an arrangement with the Harbour Light facility of the Salvation Army. It is an interim measure, and while all agree that it is a big step forward, there is a lot of controversy about the best location and function of a detoxification unit.

The principal argument against having a detoxification unit as part of a general hospital is based on the claim that costs per patient-day are higher in a hospital than they are in a separate unit. This is a fallacious argument based on a kind of bookkeeping that ignores true costs. The principal argument favouring a hospital location is based on the fact that some cases involve complications that require acute care, including sophisticated diagnostic services and around-the-clock services of a doctor. Taking everything into consideration, there seems to be a strong argument for a hospital location. On the other hand, both manager and doctor at the Detoxification Centre are satisfied that the vast majority of alcoholics can be handled satisfactorily in their type of unit.

A much larger question is that of the future place of the jail in the detoxification programme. With a growing attitude favouring the view that alcoholism is a disease, there is increasing support for those law officers who maintain that the alcoholic should be processed in a medical facility and not in the courts.

There appears to be a great deal of evidence supporting the contention that detoxification services should provide for a stay of up to ten days, or even longer in some cases. This longer stay should not only serve to take the patient safely past the worst stage of withdrawal, but to get physical rehabilitation under way and improve the patient's chances of making the grade in whatever setting he goes into next, even if it is back to Skid Road.

At one hospital in the Province, that was given full marks for its handling of detoxification, AA members help ease the demands on nurses by sitting with men who are going through the worst stages of withdrawal, and thereby strengthen their own resolve to stay sober.

1970

CHAPTER 10

An Act respecting The Alberta Acoholism and Drug Abuse Commission

(Assented to April 15, 1970)

HER MAJESTY, by and with the advice and consent of the Legislative Assembly of the Province of Alberta, enacts as follows:

Short title

1. This Act may be cited as *The Alcoholism and Drug Abuse Act.*

Definitions

2. In this Act,

(*a*) "alcoholic" means a person who suffers from the illness of alcoholism;

(*b*) "alcoholism" means any dependent condition produced by the action of alcohol upon the human system;

(*c*) "by-laws" means the by-laws of the Commission;

(*d*) "Commission" means The Alberta Alcoholism and Drug Abuse Commission;

(*e*) "drug abuse" means

(i) addiction to a substance other than alcohol, or

(ii) the use, whether habitual or not, of a substance other than alcohol that is capable of inducing euphoria, hallucinations or intoxication in the human body;

(*f*) "drug user" means a person who

(i) is addicted to the use of a substance other than alcohol, or

(ii) uses, whether habitually or not, a substance other than alcohol for the purpose of inducing euphoria, hallucinations or intoxication.

Incorporation of Commission

3. (1) There is hereby created a corporation with the name "The Alberta Alcoholism and Drug Abuse Commission" which shall consist of not more than 12 members appointed by the Lieutenant Governor in Council during pleasure.

(2) The Lieutenant Governor in Council shall designate one of the members of the Commission as Chairman and another as vice-chairman.

(3) The Commission may pay to each member of the Commission

(*a*) fees for attending meetings of the Commission, at a rate fixed by the by-laws but not exceeding $20 for each meeting, and

(*b*) his reasonable travelling and living expenses while absent from his ordinary place of residence and in the course of his duties as a member of the Commission, in accordance with the by-laws.

(4) The Lieutenant Governor in Council may prescribe the terms of office of any or all of the members of the Commission.

(5) The head office of the Commission shall be at or near Edmonton.

Meetings

4. (1) At a meeting of the Commission the vice-chairman shall preside in the absence of the chairman and where the chairman and the vice-chairman are both absent, the members present may elect one of their number to preside at that meeting.

(2) A majority of the members of the Commission constitute a quorum of the Commission.

(3) The affirmative votes of a majority of the members present at any meeting of the Commission at which a quorum is present are sufficient to pass any resolution or by-law to bind all the members.

(4) Where one or more vacancies occur on the Commission, the remaining members may exercise all the powers of the Commission.

(5) At its meetings, the Commission may exercise any of its powers by resolution except where it is required by this Act to exercise a power by by-law.

(6) A copy of the minutes of each meeting of the Commission shall be furnished to the Minister.

By-laws re meetings

5. The Commission may make by-laws respecting the calling of meetings of the Commission and the conduct of business thereat, the duties and conduct of members and generally as to the conduct of the business and affairs of the Commission.

Officers and employees

6. (1) The Commission may appoint

(*a*) an executive director, subject to the approval of the Lieutenant Governor in Council, and

(*b*) such other officers and employees as it requires

and may prescribe their duties and their remuneration.

(2) The appointment of officers and employees of the Commission shall be during pleasure unless otherwise agreed between the Commission and the officer or employee.

(3) The Commission may obtain the services of any agents or advisors or persons providing technical or professional services of a kind required by the Commission in connection with its business and affairs.

(4) *The Public Service Pension Act* applies *mutatis mutandis* to the officers and employees of the Commission as if they were employees of the Government.

(5) *The Crown Agencies Employee Relations Act* applies to the Commission and its employees as if the Commission were an agency of the Crown in right of Alberta.

Members not personally liable

7. The members, officers and employees of the Commission and persons acting under the instructions of any of them or under the authority of this or any other Act or the by-laws are not personally liable for any loss or damage suffered by any person by reason of anything in good faith done or omitted to be done in the exercise or purported exercise of any powers given by this or any other Act or the by-laws.

Secrecy of information

8. (1) Except as otherwise provided in this section

(*a*) a person who is or has been a member or employee of the Commission or is or has been employed or engaged in the administration of this Act shall not disclose or be compelled to disclose any information obtained by him that pertains to a patient or the treatment, care or services provided by the Commission to a patient, and

(*b*) any file, record, document or paper in the custody of the Commission that pertains to a patient or to the treatment, care or services provided to a patient shall not be disclosed to any person or be admitted in evidence in any proceedings.

(2) In this section "patient" means a person who has been provided with treatment, care or other services by the Commission or at any hospital, clinic or centre operated by the Commission.

(3) Subsection (1) does not apply

(*a*) where the disclosure is necessarily made in the course of the administration of the business and affairs of the Commission or in the course of the administration of this Act, or

(*b*) where the disclosure is made at the request of or with the consent of the patient concerned, his personal representative or the committee of his estate, or

(*c*) in any special case where permission is given by an order of the Lieutenant Governor in Council.

(4) Information in the hands of the Commission pertaining to patients and the treatment, care and services provided to patients may be published by the Commission or the Government in statistical form if the individual names of patients are not thereby revealed or made identifiable.

(5) A person who contravenes a provision of this section is guilty of an offence and liable on summary conviction to a fine of not more than $500 and in default of payment to imprisonment for a term not more than 90 days.

Audit

9. The Commission is subject in respect of its accounts and financial transactions to audit by the Provincial Auditor once in each year and at such other times as the Lieutenant Governor in Council may direct.

Fiscal year

10. The fiscal year of the Commission is the period from the 1st day of April to the next succeeding 31st day of March.

Budget

11. The Commission shall before the 1st day of December in each year, prepare and present to the Executive Council its budget for the Commission's next ensuing fiscal year.

Annual report

12. (1) The Commission shall annually, after the end of its fiscal year, prepare a general report summarizing its transactions and affairs during its last fiscal year and showing its revenues during that period, together with an audited balance sheet of its accounts and financial transactions during that period and such other information as the Lieutenant Governor in Council may require.

(2) When the report is prepared, the President of the Executive Council shall lay a copy of it before the Legislative Assembly if it is in session and if not, within 15 days after the commencement of the first session in the next ensuing year.

Advances to Commission

13. The Provincial Treasurer shall, from time to time as required, advance to the Commission moneys appropriated by the Legislature for the purposes of the Commission in equal monthly instalments or on any other basis agreed to by the Commission and the Provincial Treasurer.

Borrowing powers

14. The Commission, with the approval of the Lieutenant Governor in Council and to the extent permitted by the Lieutenant Governor in Council,

(*a*) may from time to time borrow money from any person or enter into overdraft arrangements with a chartered bank or a treasury branch, for the purpose of meeting its obligations as they become due, and

(*b*) may give security for the repayment of such moneys.

General powers

15. In addition to the powers vested in the Commission by section 14 of *The Interpretation Act, 1958* and by this Act, the Commission may

(*a*) subject to the approval of the Lieutenant Governor in Council, acquire and hold any real property required for its purposes, and sell or otherwise dispose of any real property no longer required for its purposes;

(*b*) accept subscriptions, donations, devises and bequests of real or personal property;

(*c*) make such banking arrangements as are necessary for the carrying out of its duties and functions;

(*d*) draw, make, accept, endorse, execute and issue promissory notes, bills of exchange and other negotiable or transferrable instruments.

Programs

16. The Commission may

(*a*) hold, administer and manage the property and assets of the Commission, subject to any directions in that regard made by the Lieutenant Governor in Council;

(*b*) subject to the approval by the Lieutenant Governor in Council, operate hospitals for the diagnosis of alcoholism and drug abuse and the treatment and care of alcoholics and drug users;

(*c*) operate clinics and centres for the observation and treatment of alcoholics and drug users in conjunction with the Commission's hospitals or at any other place in Alberta;

(*d*) provide the equipment necessary for the proper operation of the Commission's hospitals, clinics and centres;

(*e*) provide the necessary facilities for proper medical attendance, nursing and medicine at the Commission's hospitals, clinics and centres;

(*f*) provide through its hospitals, clinics and centres, or the facilities of other agencies, counselling and follow-up services for alcoholics and drug users and former alcoholics and drug users;

(*g*) subject to approval by the Lieutenant Governor in Council

(i) provide financial or other assistance to persons or bodies of persons conducting programs for the treatment or rehabilitation of alcoholics or drug users or for studies, investigations or research on alcoholism or drug abuse, or

(ii) conduct, or engage other persons to conduct, studies, investigations and research on alcoholism and drug abuse and methods of treating or rehabilitating alcoholics and drug users;

(*h*) conduct programs for the dissemination of information respecting alcoholism and drug abuse and to stimulate academic education and professional orientation respecting the recognition of, and effective response to, the treatment and care of alcoholics and drug users;

(*i*) enter into agreements

(i) with hospitals or other institutions for the accommodation, treatment and care of alcoholics and drug users, or

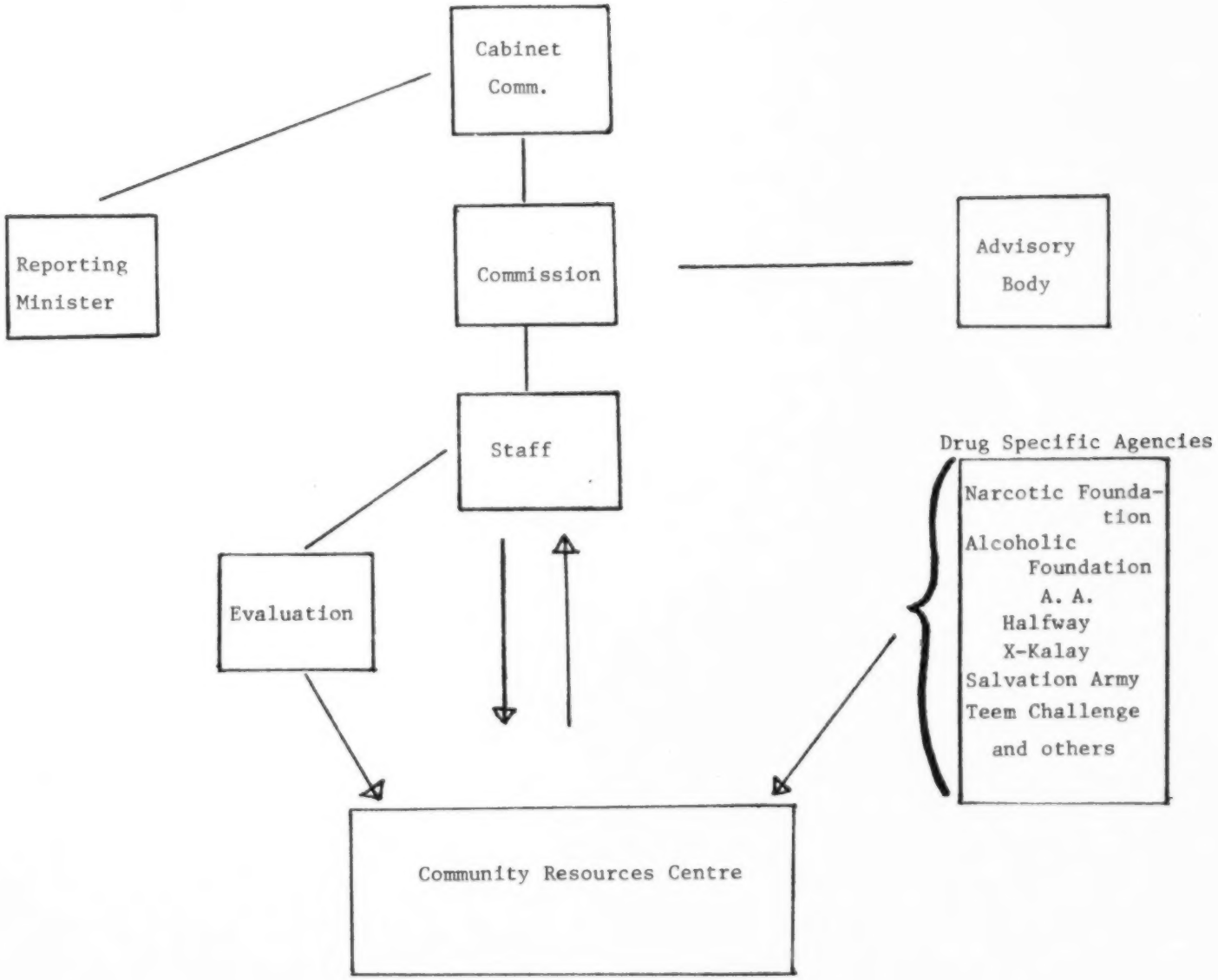
(ii) with universities, hospitals or other institutions for the purpose of conducting studies, investigations or research on alcoholism and drug abuse and methods of treatment of alcoholics and drug users.

Regulations

17. The Lieutenant Governor in Council may make regulations providing for any matters considered necessary for the purpose of carrying out the provisions of this Act.

Coming into force

18. This Act comes into force on July 1, 1970.


Cabinet
Comm.
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Advisory
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Drug Specific Agencies
Narcotic Foundation
Alcoholic
Foundation
A. A.
Halfway
X-Kalay
Salvation Army
Teem Challenge
and others
Evaluation
Community Resources Centre

THE COST OF ALCOHOL ABUSE

(a) Costs to Government

One of the more detailed attempts to estimate the cost to government of alcoholism was made in Shelby County, Tennessee in 1969. While cost will obviously depend upon the health, welfare, correction and other services of the jurisdiction involved, these Tennessee costs provide a reasonable basis for estimating British Columbia costs. The main coss categories are described briefly as follows:

HEALTH: Money costs of alcohol-related public health services.

EDUCATION: Approximately 1% of the educational payroll plus the cost of alcohol-related education.

EMPLOYMENT: Estimated loss of productivity was 25% (of the payroll) for 4% of government employees. (Education staffs were segregated.)

WELFARE: (Due to alcohol) Included portions of child and disability welfare, and cost of institutions for delinquents.

WORKS: Public works, parks, and government property maintenance or repair due to litter and abuse by drinkers in general.

SAFETY: Control or service costs to government arising from alcohol induced crimes, fire and accidents (including motor vehicle accidents).

COURTS: Judicial costs attributed to alcohol-related crimes.

Estimates of 1969 government expenditures per capita based on a population of 678,000 were as follows[1]:

HEALTH	$10.30
EDUCATION	.61
EMPLOYMENT	1.74
WELFARE	5.09
WORKS	.36
SAFETY	25.20
COURTS	2.64
	$45.94

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1 *American Business Men's Research Foundation. Report on Alcohol Vol. XXIX. No. 3 (FALL 1971) p. 43, Elmhurst, Illinois - figures recalculated on per capita basis.*

(b) Costs to Individuals and Private Organizations

Family breakdown, serious injury, death and dismemberment are serious losses that have no dollar equivalent. Such costs are excluded here. Actual production losses are unknown, but the number of problem drinkers in the labour force has been estimated at 3 to 4% and their average loss of productivity due to inefficiency, absenteeism and turnover at 25% [2], [3]. The estimated production loss is, therefore, about 1% of personal earned income, which amounts to $85 Million in B. C. on earned income of $8.5 Billion (1972 est.). This works out to $38 per capita per year and covers production losses in both the public and private sectors.

Half of all motor vehicle accidents are the result of driving under the influence of alcohol. In 1970 this amounted to $22 Million in property damage in B. C. or $11 per capita [4].

At least a portion of the cost of alcoholic beverages must be included. In 1972 this will total about $240 Million in B. C. Of the $60 Million spent by hazardous drinkers, the portion leaving the Province in taxes, profits and purchase costs is estimated at 35-40%, or about $10 per capita.

(c) Cost to British Columbia

Adding the components of cost for the public and private sectors outlined in the previous sections, and allowing for cost increases since 1969, a rough picture of the per capita dollar cost of alcohol abuse in B. C. in 1972 is the following:

HEALTH	$12
EMPLOYMENT	38
WELFARE	6
SAFETY	29
COURTS	3
PROPERTY	12
OUTSIDE B.C.	10
Total	$110

The total dollar cost of alcoholism to British Columbia is, therefore, approximately $250 Million annually.

Currently the Provincial Government is spending about $3 Million per year on programs and facilities for alcoholics. Part of this money, in particular some of the welfare and Alouette River Unit funds, would be spent even if the alcohol problem did not exist.

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2 *The Alcoholism Res. Foundation of B.C. "Damage Control and Industrial Alcoholism: A Guide for Management", Vancouver 1970, p. 12.*

3 *The American Business Men's Research Foundation. Report on Alcohol Vol. XXIX. No. 4 (WINTER 1971) p.34, Elmhurst, Illinois.*

4 *McRae E.E. "Alcohol Dependency - The Extent of the Problem", (1972 Vancouver), Alcoholism Foundation of B. C.*

COSTS IN BRITISH COLUMBIA

As one well publicized account has put it, if there were 10,000 addicts of heroin in the Province using $20 caps per day each, that is $400,000 per day or $146 Million per year being spent on this one drug. NAF figures show that hard-core heroin addicts spend an average of about $50 per day to support their habit. Estimates are particularly difficult to make since users have their own little economic society. Some steal from the public, some from other addicts, some sell to other addicts, some have non-financial ways of obtaining the drug, for example, by acting as runners or performing other tasks in the drug trade.

No usable estimates of the cost of other drugs has come to our attention. Although this is much less than for heroin, it would obviously add to the total. We are then faced with the fact that "business" of well over $100 Million is being diverted from more useful channels.

To this can be added the associated costs of extra law enforcement, hospital and medical costs, lost production, property damage, welfare and rehabilitation costs--not just the costs now incurred, but those that would need to be incurred if the problem was to be fully met and significantly reduced. It is not possible to transfer the per capita cost analysis for alcoholism to the drug picture, but it does give some insight into the relative importance and values of some elements.

Despite the obviously crude nature of the available numbers and estimates, it becomes clear that the cost to British Columbia of the problem of drug abuse is approaching the cost of alcohol abuse.

APPENDIX "F"

" C O P Y "

Taken from "The Journal" - Volume 1, No. 6 - Published Monthly by the Addiction Research Foundation -- by Milan Korcok

AMSTERDAM - The status of drug education in the United States, characterized by misinformation and irrelevance, has been termed a "catastrophe" by Peter G. Hammond, Executive Director of the National Coordinating Council on Drug Education.

Addressing the 30th International Congress on Alcoholism and Drug Dependence, Mr. Hammond condemned many existing print and film materials as not only being useless but in many respects possibly contributing to increasing drug use.

In supporting this contention Mr. Hammond cited the National Education Association's report on drug education in America, which this summer stressed that "the use of false, poor, emotionally-oriented and judgemental material is more harmful than no materials at all."

"Public hysteria fed by misinformation has pushed us to short term action solutions, and the well-publicized rush to act has too often only worsened the situation it was meant to correct," he said.

"More than 80% of existing drug abuse education films contain scientific or medical mis-statements about drugs and drug effects," says Mr. Hammond. He added that one third of them contain so many errors that the NCCDE has classified them as scientifically-unacceptable.

"The only thing they seem to do well is to show the proper administration of illegal drugs."

He added that after systematically reviewing more than 300 films during the past three years, the NCCDE can barely recommend 13.

The situation with posters, charts, dial wheels and educational literature is much worse, says Mr. Hammond. In this respect the Council will probably recommend about 30 pieces of literature from among 800 separate items under evaluation.

Much of the disarray in the field of drug education was caused by the public's failure to understand the nature of the problem, says Mr. Hammond.

"We set up all the wrong goals for our education effort, or we failed to articulate any goals at all. Drug education was introduced into school curricula, generally in the physical education department, and we thought we were right on target.

"Our goal was to standardize drug learning just as we have done with lessons on brushing teeth, combing hair or waiting until you're old enough to take a drink."

Despite his condemnation, Mr. Hammond expressed some hope that education could still fulfill an optimal role in the prevention of drug misuse. But to achieve this would require a massive reallocation of priorities, resources and energies.

Mr. Hammond noted, for example, that in the United States, the federal government spends $18,750 per drug arrest, approximately $8,500 to rehabilitate one drug addict per year or $1,500 to maintain him on methadone for the same period of time.

By comparison, only about 26 cents per capita per year for every child 12 years old and younger is spent to deter him from becoming an addict in the first place. Most of the money is spent on teacher training programs at a time when "credibility and capability of existing educational institutions are themselves in great question."

Mr. Hammond urges that more emphasis be placed on the functions of drug use rather than their psychological and physiological effects." It (education) should abandon charts, films and ex-addict testimonials for group process, rap sessions, role playing and alternative behaviour."

Such concepts would give new emphasis to parental drug use habits, views of law and authority, child rearing goals, parental acceptance of youthful self-expression, infant health, attitudes, childhood food habits and "a host of other variables missing from our current drug education vocabularies."

This would also enhance the potential roles of churches, unions, parent associations, youth groups, service organizations, neighbours and businessmen.

As Mr. Hammond sees it, this "process education" would be set outside the classroom.

"The teachers would be every participant. The students would be every participant. And the subject might, from time to time, be drugs."

Much of the problem to date has been precipitated by a failure to question intentions and assumptions, to define the problem correctly, to establish realistic goals, to evaluate the validity of messages and messengers.

As well, there has been far too much emphasis on the role of "so-called fact."

The role of facts is unclear, says Mr. Hammond. "Teaching facts as the basis for decision-making assumes we use facts in decision-making." Yet, there has been little evidence to show that information actually plays a dominant role in relation to one's decision to use drugs, he adds.

"Presentation of just the facts, might well lead people to conclude that even the powerful illicit substances do produce pleasure and can be used with little risk."

Drug education should not neglect information, says Mr. Hammond, but one should assume "that information does not influence behaviour until it is processed by an individual in terms of his own experiences, feelings and life style."

APPENDIX "G"

KNOWN STREET OR CRIMINAL ADDICT POPULATION AND HEROIN CONVICTIONS

1964 - 1971

January 1 - November 30, 1972

	ADDICTS	ADDICTS UNDER 20	CONVICTIONS
1964	2947	30	272
1965	3180	37	266
1966	3182	15	221
1967	3335	25	348
1968	3459	12	279
1969	3733	23	310
1970	4655	194	383
1971	6425	401	502
Jan 1 - Nov 30/1972	8200	-	624

(Approximate - figures not as yet completed)

	% of Population	% of BCC Addict File	No. of Total Methadone-Maintained Patients in Canada
British Columbia	10%	64%	62%
Alberta	7.58%	5.43%	9.7%
Saskatchewan	4.2%	1.98%	3.1%
Manitoba	4.54%	2.77%	3.9%
Ontario	36%	19%	16%
Quebec	28%	6.15%	5.75%
Nova Scotia	2.94%	0.28%	--

STATEMENT OF METHADONE IMPORTS

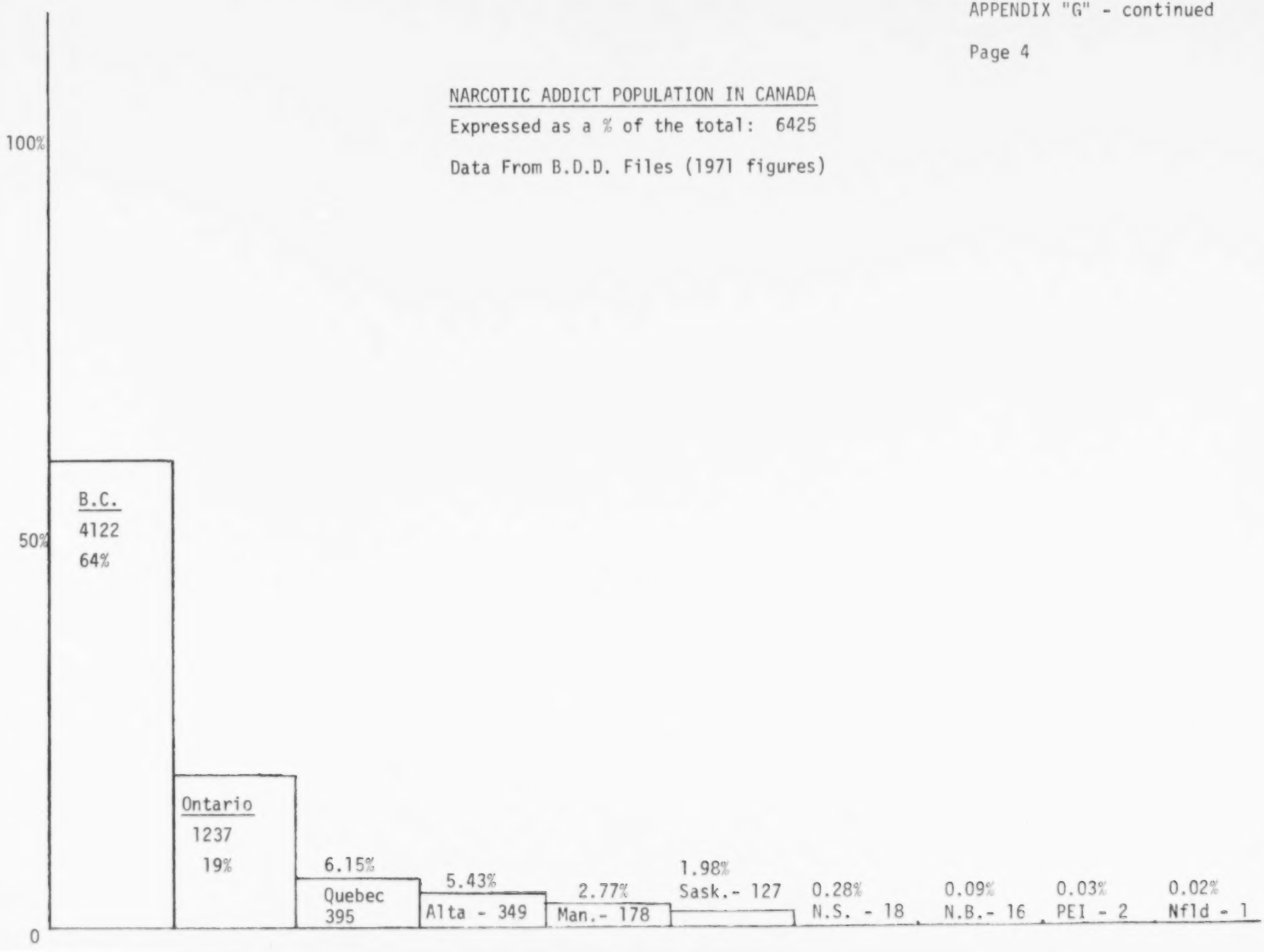
1966 -- 1971 INCLUSIVE

1966	2.7 KILO
1967	5.1 KILO
1968	9.5 KILO
1969	11.7 KILO
1970	27.1 KILO
1971	40.6 KILO

NARCOTIC ADDICT POPULATION IN CANADA

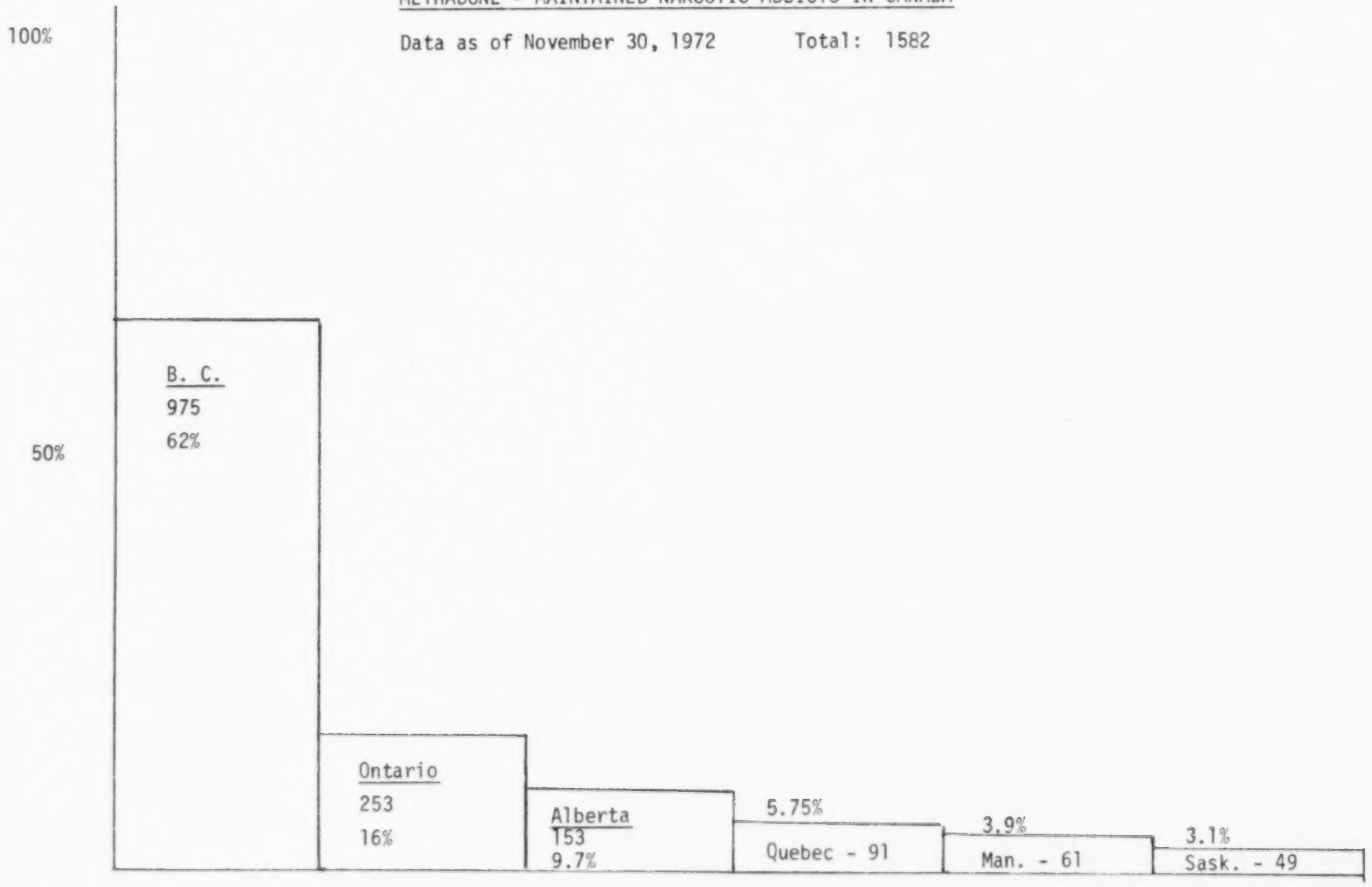
Expressed as a % of the total: 6425

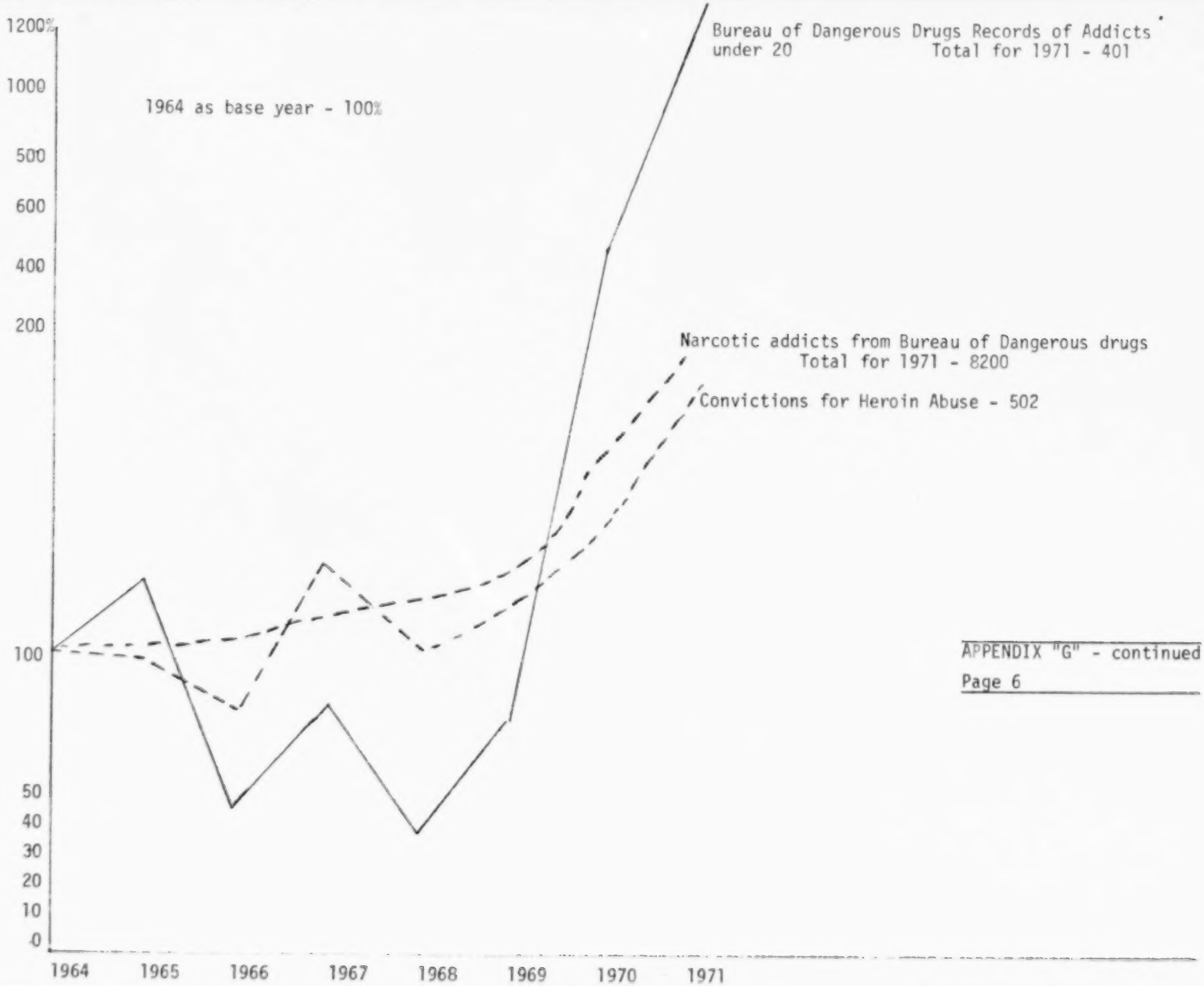
Data From B.D.D. Files (1971 figures)



METHADONE - MAINTAINED NARCOTIC ADDICTS IN CANADA

Data as of November 30, 1972 Total: 1582




1200%
1000
500
600
400
200
100
50
40
30
20
10
0
1964
1965
1966
1967
1968
1969
1970
1971
1964 as base year - 100%
Bureau of Dangerous Drugs Records of Addicts under 20 Total for 1971 - 401
Narcotic addicts from Bureau of Dangerous drugs Total for 1971 - 8200
Convictions for Heroin Abuse - 502

APPENDIX "H"

Hereunder is a copy of a letter from the Personnel Officer, Department of Rehabilitation and Social Improvement.

The Honourable Norman Levi, Minister
Department of Rehabilitation
and Social Improvement
BUILDINGS

January 18th, 1973

Re: Alcoholism In the Civil Service

Please refer to your request of January 2, 1973 concerning the problem of alcoholism in the public service. I have checked the matter through Dr. John H. Smith, Director of the Division of Occupational Health, and also through the Civil Service Commission.

It seems there are an estimated 1,050 people within the Government Service who have a problem severe enough to affect working habits. The cost to Government is estimated at approximately 1.5 to 2 Million Dollars per annum. As you are no doubt aware, there are over 30,000 employees in the Provincial Service. I am sure our Department would carry its share of those with alcohol problems; although to date, very few cases have come to my attention.

Attached are copies of letters and material relating to the problem, including a policy statement from the Chairman of the Civil Service Commission and a letter to the Chairman from Dr. Smith outlining a study he conducted recently. Also attached are copies of a Civil Service Commission Bulletin concerning the problem which is sent to all employees who reach a supervisory position.

C. R. Spence
PERSONNEL OFFICER

CRS/sgp

Enclosures

cc: Deputy Minister

THE EMPLOYEE WITH A DRINKING PROBLEM # 1

What should you, the supervisor, do if you are reasonably convinced that one of your employees has or is developing a drinking problem?

Certainly you should not ignore the problem or laugh it off! Often, because of a sincere concern for the employee's family, supervisors feel justified in ignoring the situation. They 'cover-up' the employee's increasing absenteeism, and his uneven work performance; they refuse to 'see' the evidence of his drinking habits. These supervisors are really doing the employee, his family and the Department a disservice because the earlier the cards are put on the table, the earlier constructive action can be taken.

Alcoholism is an illness unlike most in that the person affected will not voluntarily seek assistance or treatment; indeed, he is quite convinced that he does not have a drinking problem; and that he can stop drinking whenever he wants to. The reality is that the alcoholic can very, very rarely control his drinking habit without help. He needs help -- immediate, firm, and continuing help. If you, the supervisor, ignore the signs, you are merely fortifying the employee's false opinion that no problem exists ... and the problem grows and grows.

Because of your day-to-day contact with your employees, you are in the best position to recognize the problem drinker. Indeed, it is your responsibility to identify the employee whose drinking habits are interfering with his work performance, his attendance and his relationship with you and your staff. If you have earned the respect and trust of the employee, you may be able to persuade the employee to see his doctor or to seek help from one of the community agencies staffed with personnel trained to help persons with a drinking problem. You should certainly make a personal effort to have the employee face up to the fact that he has a health problem which he cannot solve without help. The problem drinker must take one important step if he wishes to control his drinking habits; he must acknowledge that he has a problem with alcohol and that he needs assistance and treatment. As his supervisor, you must do everything you can to get the employee to take this initial step.

You should keep accurate records of any incidents which indicate the employee has a drinking problem, of any discussions you have with the employee, of any letters you may write him, and of any reports, verbal or written, which you may make to your superiors about the situation.

Here are some of the signs which will help you to recognize an employee who has a drinking problem:-

A decline in work performance
Failure to complete work assignments on time
Increased absenteeism, especially around weekends and paydays
Frequently edgy, irritable
Avoiding supervisor and associates
Increased secretiveness about his activities
Frequent trips to the washroom
Use of "breath purifiers"
Hand tremors
Hangovers on the job
Drinking at lunch time
Drinking furtively on the job

Some of these signs may, of course, indicate a health problem not related to drinking, but collectively, they indicate a drinking problem. Some alcoholics use cough medicine bottles to disguise liquor, so do watch the employee who takes frequent trips to the washroom to "take medicine". Review your sick leave records regularly so that you can spot the employee with an above average sick leave taken on his own signature. The employee with a drinking problem normally has an absentee record four or five times greater than the average. Remember too that not all absenteeism is formally recorded:- the alcoholic may disappear from his immediate work area to sleep off a hangover; or he may report to work, then complain of feeling ill and leave a short while later. So be alert to any unusual patterns of behaviour.

As a layman, you may rightly feel that you cannot 'diagnose' the problem as being alcoholism; but you can, indeed, must urge any employee with a high absentee record to see his doctor immediately. Obviously, his repeated absences are having a serious effect on the work production. As the employee's supervisor, you are more likely to succeed in getting him to seek help if you stress the effect his drinking problem is having on his job, his health and family. Then, too, it may help if you inform the employee that the Department and Civil Service Commission regard a drinking problem as an illness and that, if he seeks treatment, he will be allowed some use of his sick leave credits for rehabilitation purposes.

A team approach is usually most successful in helping a problem drinker back to good health. Do not hesitate to ask the Alcoholism Foundation, the local Alcoholics Anonymous Chapter, your superiors, or the Director of the Occupational Health Service of the Health Branch for help with this problem.

Tips for Supervisors (Number 17) will outline the Civil Service Commission's policy with respect to employees with a drinking problem, and the procedures you should follow in dealing with his problem.

THE EMPLOYEE WITH A DRINKING PROBLEM # 2

The Civil Service Commission recognizes that alcoholism is an illness which requires treatment, and will offer the employee with a drinking problem the same consideration he would receive for any other illness. Sick leave will be authorized whenever absence from work is necessary for treatment or hospitalization.

But what do you do if the employee refuses to acknowledge he has a drinking problem? You should take the same disciplinary action you would take with any employee whose work performance is unsatisfactory, such as:-

(a) If the employee has a salary increment due in the immediate future, you should complete an Employee Appraisal Form recommending that the increment be withheld. You should discuss with the employee your reasons for making this recommendation, and spell out, very clearly, the steps you will take if he fails to meet the work standards. Be specific as to these actions and the time limits.

(b) If no salary increment is due you should complete an Employee Appraisal Form and use this as the basis for a frank discussion with the employee. Here, too, you must set out the course of action you will take if no improvement is shown within a specified time limit.

In both (a) and (b) it is essential that you follow-up your discussion with the employee by writing him a formal letter setting out the steps you will take. You should also take this opportunity to encourage him to seek help immediately from his doctor, the Alcoholics Anonymous, the Alcoholism Foundation or the Director of Occupational Health Service, Health Branch, 828 West 10th Avenue, Vancouver.

(c) You should inform the employee that until he seeks treatment, you will not approve any sick leave on his own signature. In this way, you may motivate the employee to go to his doctor or to one of the community agencies.

(d) If within one month after your discussion with the employee, no improvement is shown, you should recommend suspension with no intent to dismiss for a period of one month. The loss of salary may shock the employee into recognizing that he does have a drinking problem, that his job is at stake, and that he needs help.

(e) If it is apparent within one month after the employee has returned to work following the suspension that he has not sought treatment, and has no intention of seeking help, then you have no alternative but to recommend suspension with intent to dismiss.

All of these steps have one objective ... to try to get the employee to seek help.

If the employee does seek help with his drinking problem, your role should be one of help and encouragement. You should arrange to meet with the employee on a regular basis. Find out as much as you can about the treatment program and his progress. The early stages of treatment are critical. This is a very difficult time for the employee, a time when he may be tempted to, or indeed may, slip back into his former habits. Often, the supervisor can, by showing confidence in the employee's ability to overcome his drinking problem, help him to do just that!

Don't feel that the battle is lost if there is some 'back-sliding'. If you need guidance from the treatment agency, do ask for it. However, in most cases your knowledge of the individual employee will help you to make the correct decision regarding the most effective steps you should take if and when back-sliding occurs. Your actions should neither be too soft, nor too hard. Our experience has shown that it is usually, not always, but usually, unwise to recommend suspension during the early stages of treatment as this action normally leads to further drinking.

The employee should, of course, be made fully aware that he must co-operate fully in the treatment program, and that his work performance must meet the standards required within a specific time. He should know that you will not approve sick leave with pay until he proves he is sincere in his efforts to rehabilitate himself.

If the employee discontinues treatment it may, of course, be necessary to recommend dismissal. Usually, though, once a person has acknowledged he has a drinking problem and accepts treatment, you can with patience, understanding and firmness help the employee to conquer his drinking habits.

Without taking any credit away from the treatment agency, we want to stress that you are the key to the rehabilitation program. Because of your day-to-day contact with the employee, you can identify the employee with a drinking problem; you can direct him to a source of treatment; and you can give him the support he needs during the treatment program. Yours is not an easy task, but it can be very rewarding when the employee regains his health and once more becomes a productive employee.

ADDRESS ALL COMMUNICATIONS TO THE CHAIRMAN
CIVIL SERVICE COMMISSION

PLEASE QUOTE:
OUR FILE
YOUR FILE

PARLIAMENT BUILDINGS,
1544 MICHIGAN STREET,
VICTORIA, BRITISH COLUMBIA

TELEPHONE 382-6111
CHAIRMAN - - - LOCAL 2680
GENERAL OFFICE - LOCAL 2687
RECEPTION - - - LOCAL 2666

CIVIL SERVICE COMMISSION
VICTORIA

September 21st, 1971.

MEMORANDUM TO DEPUTY MINISTERS, PERSONNEL OFFICERS AND EQUIVALENT AUTHORITIES:

Re: Policy on Alcoholism - Provincial Government Employees.

Discussions have been held with the Director of the Alcoholism Foundation of British Columbia and our Director of Occupational Health, concerned with a policy with respect to dealing with problems of alcoholism within the Service. As a result of these discussions, the following policy has been instituted:-

1. Alcoholism or problem-drinking is an illness which requires treatment;

2. That competent assistance be given to employees who develop alcoholism by referring them to the Director of Occupational Health;

3. That it is the responsibility of the employee who develops alcoholism, as it is in any form of illness, to seek treatment;

4. That sub-standard performance due to alcoholism, as in any form of illness, should not be tolerated;

5. That alcoholism, as in any form of illness, should be diagnosed and treated at the earliest possible stage, and should be dealt with on a confidential basis.

6. In order to preserve the confidential nature of alcoholism, individual employees may contact the Director of Occupational Health directly, if they choose.

A.G. Richardson,
CHAIRMAN.

AGR/ds.
Circular 33/71

Hereunder is a copy of a letter from John H. Smith, M.D., D.P.H., D.I.H, Director, Division of Occupational Health, Department of Health Services and Hospital Insurance.

Mr. A. G. Richardson
Chairman
Civil Service Commission
Parliament Buildings
VICTORIA, British Columbia May 15th, 1972

Dear Mr. Richardson:

In your letter of April 20th, you asked for details as to costs that could be attributed to alcoholism or problem drinking, as a result of lost time or poor performance. Please find attached a report to the Special Sub-committee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare, October 1970 - it states in Chapter 2, Page 9, that direct and indirect loss occurs when a company tolerates alcoholism. This is due to absenteeism, accidents, bad decisions, discharges, dissention in work groups, early retirement, garnishments, lost sales, lowered worker efficiency and morale, overtime payments necessitated by absent workers, safety hazards, and unfavourable public relations in the community.

As may be noted, some of the areas of loss are of an intangible nature and not readily susceptible to cost measurement. It goes on to state further, "the National Council on Alcoholism estimates that it costs employers an amount equivalent to about twenty-five percent of the average annual pay of each alcoholic employee. We were informed by the National Council official that absenteeism of an alcoholic employee was two or three times greater than that of the average non-alcoholic employee". Other authorities state that twenty-five percent loss of average annual pay was too low. The estimate of the possible alcoholic or problem drinkers among the 2.8 million Federal civilian employees as of June 1970, ranged from four to eight percent. A conservative figure for British Columbia would be 3.5 percent of the population are alcoholic. This figure, in my opinion, could apply easily well to the 30,000 employees we have in the Civil Service.

As a result, we can consider approximately 1,050 of our employees have problems with alcohol, if one uses the twenty-five percent figure mentioned earlier, and the average income of the employee is approximately $7,800.00, one can then see there is a loss of over $1,970.00 per annum per employee, adding up to a total of slightly over Two Million Dollars for 1,050 employees.

Other industries, such as Gulf Oil Company, estimate that direct and indirect cost to the company as a result of problem drinking is $1,300.00 per person per year. This when applied to our 1,050

employees amounts to a loss of $1,350,000.00. So I would estimate that the cost to the British Columbia government ranges somewhere between these two figures.

It is my feeling that with a problem of this magnitude, a request eo employ one officer to implement the program is a very modest one indeed. As you are aware, the Council on Drugs and Alcohol are very sympathetic to the program, but will have to await a request from the Commission.

If you wish to have further information, I would be happy to supply whatever is needed.

Yours sincerely,

JOHN H. SMITH, M.D., D.P.H., D.I.H.
Director
Division of Occupational Health

JHS/js

PREVALENCE OF PROBLEM DRINKING IN CANADIAN INDUSTRY

It has been suggested thab businesses and industries across Canada open their doors each morning to a multi-million-dollar hangover. The exact cost of the hangover cannot be determined but, using the loss assessed by one company and relating it to the estimated 250,000 alcoholics in Canada, the overall cost of alcoholism to Canadian industry could be as high as $325 Million a year.

Mr. C. D. Shepard, Chairman of British American Oil Company*, has stated that 300 of the company's 10,000 employees are probably problem drinkers. "These people each lose 20 days a year as compared with 4 or 5 days for other employees. They make more mistakes."**

Mr. Shepard estimates that the direct and indirect cost to the company of these employees is $1,300 a person each year. It requires considerable effort on the part of others to make up the total annual cost of $390,000.

To illustrate a point: If Canada's manufacturing industry average profit-over-sales figure, approximately 4.5% of sales, be used with B.A.'s figures, the company would have to make $8.6 Million in sales annually to pay for the excessive drinking habits of 300 employees.

B.A. is believed to be the latest company of any size to adopt a management policy on alcoholism. It has joined ranks with other large corporate firms such as Bell Telephone, Ontario Hydro, Cominco, Ontario and Alberta governments, various federal government departments, and many Canadian subsidiaries of U.S. corporations. To date, there is a lack of alcoholism control programs in small and medium sized companies.

WHY INDUSTRIES NEED ALCOHOLISM CONTROL PROGRAMS

An industrial program cannot be justified unless it can increase profitability or solve the serious problems related to productivity. Therefore, three questions must be answered if any company is to give serious consideration to an industrial alcoholism.

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* Now Gulf Oil Company

** P. 1b, Globe and Mail, March 28, 1968.